



University of Massachusetts
325 Whitmore Administration Building
181 President's Drive
Amherst, MA 01003-9313

Division of Human Resources
Workers' Compensation
voice: 413.545.6114
fax: 413.545.0483

NOTICE OF INJURY REPORT

This form is intended for internal use for all Human Resources Division/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed via eServices within 48 hours of an Industrial Accident. Please print clearly.

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Soc. Sec. #: _____ Date of Injury: _____

Department: _____

Name: _____

(First)

(Middle)

(Last)

Sex: Male ☐ Female ☐ Employee ID#: _____ Record #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Date of Birth: _____

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Unit: _____

State Hire Date: _____ Department Hire Date: _____

Status: Full Time Employee ☐ Part Time Employee ☐ Work Hours/Wk: _____

Shift 1st ☐ 2nd ☐ 3rd ☐ Number of Days Off: _____

Occupation: (Official Position Title) _____

Functional Title: _____

Payroll Funding Source: State Payroll ☐ Trust Funded ☐ Federal Funded ☐

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Injury Time: _____ Date Reported: _____

Describe how the injury occurred: _____

Third Party Claim: Yes ☐ No ☐

Nature of Injury: _____

Injury Detail (**Choose only from the attached list, page 4**):

Select Body Part(s): _____ Select Injury: _____

Select One or More Injury Categories:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Fall | <input type="checkbox"/> Lifting | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Assault |
| <input type="checkbox"/> Exposure | <input type="checkbox"/> Repetitive Use | <input type="checkbox"/> Equipment | <input type="checkbox"/> Moving/Walking |
| <input type="checkbox"/> Stress/Heart Attack | <input type="checkbox"/> Burn | <input type="checkbox"/> Cut | |

Severity of Injury:

- ☐ (1) Minor injury; no likely lost time; no likely medical bills
- ☐ (2) Small injury; no likely lost time; possible medical bills
- ☐ (3) Moderate injury; possible lost time; probable medical bills
- ☐ (4) Significant injury; probably 0 to 5 days of lost time and medical bills
- ☐ (5) Severe injury; probably 5+ days lost time and medical bills

Where the injury occurred:

Building: _____

Injury Location: _____

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Was the incident the result of a violent act? ☐ Yes ☐ No

Was the claimant engaging in usual job activities? ☐ Yes ☐ No

If no, explain: _____

Injury reported to: _____

Supervisor: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

Manager: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

Was the incident witnessed? ☐ Yes ☐ No

If Yes, provide the names of witnesses and ask that each prepare a witness statement.

Witness: Name _____ Title _____ Tel _____

Name _____ Title _____ Tel _____

Did the claimant seek medical attention? ☐ Yes ☐ No

If yes, where? _____

Is claimant a disabled veteran or has any other known disability?

☐ Yes ☐ No ☐ Unknown

Do you feel the claimant would benefit from any referral to Rehabilitation?

☐ Yes ☐ No ☐ Unknown

Do you feel the claim warrants further investigation? ☐ Yes ☐ No

Please attach if possible any information you feel would be useful to HRD/WC Section (i.e. claimant's job description, etc.) in managing this claim.

Signature: _____ Please Print: _____

Position: _____ Date: _____

Attachment for Body Parts and Injuries

Body Parts			
Abdomen/Internal Organs/Hernia	Elbow	Knee	Scalp
Ankle	Eye	Leg, Multiple	Sciatic Nerve
Arm, Multiple	Face, Multiple Parts	Leg, NEC	Shin
Arm, NEC	Face, NEC	Leg, UNS	Shoulder
Arm, UNS	Face, UNS	Lip	Skull
Armpit	Finger	Lower Arm	Thigh
Back	Foot or Feet	Lower Extremities, Multiple	Toe
Body System	Forearm	Lower Extremities, UNS	Tongue
Brain	Groin	Lower Leg	Tooth/Teeth
Buttocks	Hamstring	Mouth & Throat	Trunk, Multiple
Calf	Hand, exc-wrists & fingers	Multiple Parts	Trunk, UNS
Chest/Breastbone	Head	Neck & Cervical Vertebrae	Upper Arm
Ear, External	Head, Multiple	Non-Classifiable	Upper Extremities, UNS
Ear, Internal	Hip	Nose	Upper Extremities, Multiple
Ear, UNS	Jaw, Chin	Ribs	Wrist

List for Injury			
Aluminosis	Chest Pains	Hernia, rupture	Other toxic effects
Amebiasis	Concussion	High Blood Pressure	Otr.Infec/Paras. Dis
Amputation/Enucleat.	Conjunct. & Ophthalmia	Inf./Parasit.Dis, UNS	Pneumoco. W. tubercu
Anthracosis	Contusion, crush, bruise	Insect Bite	Pneumoconiosis, UNS
Anthrax	Cut, Laceration, puncture	Ioniz. Radiation Iso	Poison flu/pneumonia
Anxiety Attack(s)	Dermati, allerg/cont	Ioniz. Radiation XR	Poison/systemic UNS
Asbestosis	Dermatitis, UNS	Joint Inflamm., etc.	Prim infec. of skin
Asphyxia, strangula.	Dis/blood frmg organ	Malignant Tumor	Prosthetic dv. damage
Asthma/Flu/Pneumonia	Dislocation	Med. Care Complicat.	Radiat. Effects, UNS
Atmosph.Press.Effect	Dizziness	Mental disorders	Respir. System Cond.
Benign Tumor	Due/toxic materials	Microwave	Scratches, abrasion
Bite (animal)	Effect/enviro.heat	Multiple injuries	Siderosis
Bite (human)	Effect/Lead Exposure	Nausea/Vomiting	Silicosis
Body Fluids/Saliva	Electric Shock/Electrocution	Neoplasem, tumor UNS	Skin Condition, NEC
Brucellosis	Exposure to low temp	Nerv. Sys. Condition	Sprains, strains
Building Syn/Work Environ	Eye, other eye dis.	Nerves/Ganglia Dis.	Stress
Burn (chemical)	Fracture	No injury/illness	Symptoms/ill-df. cond
Burn (heat)	Gastro/inten.dis./o	Non-classifiable	Tetanus
Byssinosis	Headache/Migraine	Non-Ionizing Radiat.	Toxic hepatitis
Carpal Tunnel Syndrome	Hear loss or impair.	Occup. Disease/NEC	Tuberculosis
Central Nervous System Disorder	Heart Cond/Attack	Other Injury, NES	Upper Resp. condit.
Cerebrovascular/Circ	Hemorrhoids	Other pneumoconiosis	Upper respiratory
	Hepatitis (ser.&inf.)	Other skin condition	Welder's flash



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**WORKERS' COMPENSATION
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

CLAIMANT'S NAME: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

EMPLOYING AGENCY AND LOCATION: _____
UMA4
UMASS AMHERST

DATE OF INJURY _____

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, ***any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law.*** I understand that HRD may share this information with my employer, medical and or vocational rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

SIGNATURE: _____

DATE: _____